Pediatric History Form

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. Many types of stressors (physical, mental, and chemical) can interfere with your child's growing brain, spine and nervous system. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Child's Name: _____Today's Date: _____ Birth Date: __/___/___

Male/Female (Circle one) Weight: _____lbs. Height: __ ft. __ in. Phone #_____

Address: _____ City: _____

State: _____Zip: _____ Parent / Guardian:

_____

Referred by: _____

Reason for pursuing care: ☐ maintenance ☐ improved health ☐ problem: _____

_____

Family history: _____

Check any of the following conditions that currently apply:

Ear infections ___ Scoliosis __ Chronic Colds __ Headaches __ Allergies

__ Digestive problems __ ADHDI ADD __ Recurring Fevers __ Colic ___ Seizures

__ Growing / back pains __ Bed wetting __ Temper Tantrums __ Asthma __ Car accident

(Please include when) _____

other 1: _____ other 2: _____

Other doctors seen for this condition (Please include doctor's names and prior treatment):

_____

Previous Chiropractic Care? Y / N Last visit: _____/_____/_____

Name of Pediatrician: _____ Last visit: _____/_____/_____

Are you satisfied with the care your child has received at the pediatrician? Y /N

# of Doses of antibiotics your child has taken: Past 6 months'_____ Total lifetime _____

Present prescription drugs/ dosage? _____

Past prescription drugs/ dosage? _____

Over the counter drugs (Tylenol, cough syrup, laxatives, etc.) _____

Child's Name _____ Date: _____

Prenatal History (Circle what applies)

Name of Obstetrician/ Midwife: _____

Complications during pregnancy/ delivery? Y /N Explain: _____

Ultrasounds during pregnancy? Y /N How many?_____

Medications taken during pregnancy/ delivery? Y /N List: _____

Cigarette/ Alcohol use during pregnancy? Y /N

Location of birth (circle one): Hospital Birthing Center Home

Birth Intervention (circle one): Forceps Vacuum Extraction Caesarian Section

If Caesarian Section, was it (circle one):

Genetic disorders/disabilities? Y /N List: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____ - _____

Feeding History

Breast Fed: Y /N How long? _____ Formula Fed: Y /N How long? _____Type: _____

Introduced to: Solid Foods @ _____months Cow's milk @ _____ months

Food/ Juice allergies or intolerances: Y / N List: _____

Developmental History (to the best of your knowledge)

Your child's spine is vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). Spinal nerve interference can affect the following. At what age was your child able to:

___ Respond to stimuli ___ Cross Crawl ____ Stand alone ___ Sit up

___ Respond to visual stimuli ___ Hold head up ____ Walk alone

According to the National Safety Council, approximately 50 of children fall head first from a high place during their first year of life (Le. a bed, changing table, down stairs)

Did your child have a fall similar to what was described above?

Y/N Explain: _____

Other traumas not described above (bike wipeout, trampoline injury, etc.)?

Has your child been involved in any sports? Y /N List: _____

_____

Childs Name _____

Has your child been seen by a physician on a n emergency basis? Y / N Explain: _____

_____

Lifestyle (please check all that apply):

Does your child eat healthy food (organic products, etc.) drink water

Take probiotics take vitamins type: _____

☐ Exercise: ☐ none ☐ mild ☐ moderate ☐ heavy ☐ daily

Hobbies/interests: _____

Is there anything else you would like us to know about your child?

_____

_____

Parent/ Guardian name: _____ Signature: _____

We love to have kid's pictures in our **office! If you would allow us to have your child's picture in the office, please sign below.**

For valuable consideration, I hereby irrevocably consent to and authorize the use and reproduction by Higher Health Chiropractic Inc., or anyone authorized by Awaken Chiropractic LLC., of any and all photographs/videos which were taken of my Child, for the purposed of promotional TV, website, social media and/or print ad Whatsoever, without further compensation to me. All negatives and positives, together with the prints shall constitute the property of Awaken Chiropractic LLC, solely and completely. Any information voluntarily provided by a patient shall also be used in conjunction with the above listed information for purposes previously mentioned. Confidentially, in regards to any reported conditions, is also waived to the extent of information pertinent to the promotion material only. I authorize Higher Health Chiropractic Inc. to share this information via their website and their Facebook/social media including Twitter and Instagram, and for use in the office. All other unrelated patient information shall remain private and protected (according to Health Information and Privacy Act laws).

Signature: _____ Date: _____

X-RAY AUTHORIZATION

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS. WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES. AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF THE X-RAYS IN OUR FILES.

PLEASE NOTE: IF X-RAYS ARE NECESSARY, THEY ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE VERTEBRAL SUBLUXATIONS. THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTORS OF HIGHER HEALTH CHIROPRACTIC INC. DO NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR A TIENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE.

IF YOUR CHILD IS AN INFANT OR UNDER THE AGE OF FIVE, IT IS UNLIKELY THEY WILL NEED CHIROPRACTIC POSTURAL XRAYS. HOWEVER, PLEASE SIGN BELOW FOR FUTURE REFERENCE.

BY SIGNING BELOW, YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS

CHILDS NAME _____CHILDS AGE _____

PARENT/GARDIAN SIGNATURE DATE _____

DO NOT WRITE BELOW THIS LINE --- DO NOT WRITE BELOW THIS LINE --- DO NOT WRITE BELOW THIS LINE